DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2018
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445170	A. BUILDING _____ B. WING _____	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HEALTH AND REHAB CENTER	500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #43690 were completed on 4/16/18 - 4/18/18 at Good Samaritan Health & Rehab Center. Deficiencies were cited during the recertification survey at a HARM (a situation in which the provider's noncompliance resulted in a negative outcome that had compromised the resident's ability to maintain and/or reach his/her hightest practical physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services) for failure to appropriately update and complete a comprehensive care plan, notify the Medical Director timely a fall occurred, and failure to provide pain management for Resident #239 which resulted in a fracture.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse	F 578	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The resident/responsible party for resident #86 was notified for validity of the correct code status 4/18/18. The Advance Directive for Resident #86 was reviewed for accuracy and completeness. The incorrect copy was removed from the chart.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 5-4-18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received 5-8-18

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F 578	Continued From page 1 medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to maintain accurate advanced directives (code status) in the electronic medical record for 1 of 42 sampled residents (Resident #86) reviewed. Findings include: Medical record review revealed Resident #86 was admitted to the facility on 3/10/18 with diagnoses including Parkinson's Disease, Heart Failure, Dysphagia, Adult Failure to Thrive and Dementia. Medical record review of the electronic medical record for Resident #86 on 4/16/18 at 4:10 PM	F 578	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** For all newly admitted residents the following steps will be performed to ensure the deficient practice will not recur; 1. Comm. Relations Staff will initiate the Advance Directive with resident and/or responsible party on day of admission. 2. Admission Nurse will verify with family to validate accuracy of Advance Directive. 3. During the Initial Care Plan Conference (24-48 hrs.) IDT Staff will review the Advance Directive with the family to Ensure completion and Accuracy. 4. Medical Records will audit For compliance.	

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F 578	Continued From page 2 and 4/18/18 at 9:50 AM revealed the resident's advanced directive (codes status) was Cardiopulmonary Resuscitation (CPR) indicating she preferred life saving interventions if she has no pulse and is not breathing. Medical record review of Resident #86's hard chart revealed a POST (Physician Order for Scope of Treatment - a document completed by a healthcare professional, signed by a Physician based on patient preferences and medical indications) form dated 3/10/18. Continued review revealed the resident preferred a code status of Do Not Resuscitate (DNR) indicating to allow natural death if she has no pulse and is not breathing. Interview with the charge nurse, Licensed Practical Nurse (LPN) #5 on 4/18/18 at 9:50 AM at the nurses station after viewing Resident #86's, home page on the electronic medical record and the hard chart copy of the POST form confirmed the electronic medical record and hard copy POST form were not the same. Further interview confirmed the hard copy POST form was the correct document to follow. The LPN (#5)confirmed the facility failed to maintain accurate code status for Resident #86 in the electronic medical record.	F 578	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director (SEE ATTACHMENT "C")	
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		

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F 580	Continued From page 3 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ll). (ll) When making notification under paragraph (g)(14)(l) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (lii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The Medical Director was notified of the "Immediate Jeopardy" citation 4/17/18 @ 8:30pm. The facility assigned a "Sitter" to be in the room with Resident #239 4/17/18 @ 7:01pm. The family was informed 4/17/18 @ 7:01pm. Resident' care plan was updated accordingly 4/17/18. The nurse assigned to Resident #239 on the day of the incident was suspended 4/17/18 @ 10:45pm.	

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F 580	Continued From page 4 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, facility investigation review, Physician Order, Nurse's Notes, Radiology Report and interview, the facility failed to notify the Medical Director/Attending Physician immediately after 1 fall by 12 residents (Resident #239) sampled/reviewed for falls. The facility's failure to notify the Physician in a timely manner resulted in prolonged pain to the Resident and HARM (a situation in which the provider's noncompliance resulted in a negative outcome that had compromised the resident's ability to maintain and/or reach his/her hightest practical physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services). Findings include: Review of facility policy "Notification of Physician & Family - Change in Resident's Condition or Status" revised 11/28/16 revealed, "...Our facility shall promptly notify the...Attending Physician...of changes in the resident's medical/mental condition and/or status...The nurse will notify the resident's Attending Physician...when there has been a(an)...accident or incident involving the resident..." Medical record review revealed Resident #239 was admitted to the facility on 3/23/18 and readmitted on 4/2/18 with diagnoses including Fracture of Unspecified Part of Neck of Right	F 580	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** In-service training was given to the nursing staff regarding Notification to physician and family beginning 4/17/18 and will be on going to ensure all staff that were not present at the first training session receive the training prior to beginning their shift. "In-service Training Sheets Attached). (SEE ATTACHMENT "E")	

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F 680	Continued From page 5 Femur, Hallucinations, Other Reduced Mobility, Muscle Weakness, Other Abnormalities of Gait and Mobility, Heart Failure, Altered Mental Status, Diverticulosis of Small Intestine, Ischemic Cardiomyopathy, Chronic Obstructive Pulmonary Disease, Adult Failure to Thrive and Acute Angle-Closure Glaucoma. Medical record review of a Discharge Minimum Data Set dated 3/26/18 revealed Resident #239 had a Brief Interview for Mental Status score of 11, indicating mild cognitive impairment and required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene and required total dependence for bathing. Continued review revealed the resident was not steady and only able to stabilize with staff assistance for moving from a seated to standing position. Further review revealed Resident #239 was at risk for falls and had a fall with major injury since admission (3/23/18). Review of a facility investigation dated 3/26/18 revealed Resident #239 had a fall resulting in fracture at 5:00 AM and the Medical Director/Attending Physician was notified at 7:30 AM and 8:30AM with no response documented. Review of a Physician's Order dated 3/26/18 at 1449 (2:49PM) revealed a phone order received by the Attending Physician for, "x ray right femur, pelvis, pelvis [sic], and right hip r/t pain." Review of a Radiology Report dated 3/26/18 at 8:02 PM revealed, "...acute fracture involving the right subcapital hip... There is a right subcapital fracture with slight displacement..." Review of a Nurse's Note dated 3/26/18 at 2100	F 680	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The facility has implemented a written "Protocol for notifying Physician and Family" when a change in the resident's condition or status occurs. (See attachment "A"). Medical Records and QAPI staff will conduct daily audits to ensure compliance.	

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F 580	Continued From page 6 (9:00 PM) revealed, "...mobile xray resultes called to MD. Order obtained to send resident to [hospital named] ER for Eval. and Tx. as ordered. AMR ambulance service to transport..." Medical record review revealed Resident #239 had a fall on 3/26/18 which resulted in a fracture (HARM). Further review revealed the resident was admitted to the hospital and received surgery on 3/28/18 to repair the fracture. Interview with the Medical Director/Attending Physician on 4/18/18 at 5:00 PM by telephone revealed he expected to be called immediately for all falls. Interview with the DON on 4/18/18 at 5:45 PM in the conference room confirmed all falls should be reported immediately to the Medical Director/Attending Physician. Continued interview revealed the survey team reviewed the above referenced fall and the DON confirmed the facility failed to notify the Medical Director/Attending Physician immediately for 1 fall for 12 residents (Resident #239).	F 580	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Plant & Maintenance Manager, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		

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F600	Continued From page 7 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on medical record review, Nurse's Notes, Physician's Orders, review of facility investigation and interview, the facility failed to provide goods and services necessary to treat pain and provide prompt medical attention which resulted in a fracture for 1 of 27 sampled residents (Resident #239) resulting in HARM (a situation in which the provider's noncompliance resulted in a negative outcome that had compromised the resident's ability to maintain and/or reach his/her highest practical physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services). Medical record review revealed Resident #239 was admitted to the facility on 3/23/18 and readmitted on 4/2/18 with diagnoses including Fracture of Unspecified Part of Neck of Right Femur, Other Reduced Mobility, Muscle Weakness, Other Abnormalities of Gait and Mobility, Heart Failure, Altered Mental Status, Diverticulosis of Small Intestine, Ischemic Cardiomyopathy, Chronic Obstructive Pulmonary Disease, Adult Failure to Thrive and Acute Angle-Closure Glaucoma. Medical record review of a Discharge Minimum Data Set dated 3/26/18 revealed Resident #239 had a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment; required extensive assistance with bed mobility,	F 600	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** At 5am, 4/27/18, time resident #239 was observed on the floor; staff assessed her for ROM, vital signs, level of consciousness and evaluated for possible injury and pain. During the assessment the resident denied pain and did not express any signs or symptoms of pain. Staff continued to monitor and conduct neuro checks. When the resident complained of pain later in the morning the Physician was called and order received for X-ray. X-ray results reveal right hip fracture. Physician order received to send resident to hospital for further evaluation and treatment. Ambulance called and arrived later in the afternoon and transported resident to hospital.	

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F 600	Continued From page 8 transfers, dressing, toileting and personal hygiene and required total dependence for bathing. Continued review revealed the resident was not steady and only able to stabilize with staff assistance. Further review revealed Resident #239 was at risk for falls and had a fall with major injury since admission. Medical record review of a facility investigation revealed on 3/26/18 at 5:00 AM Resident #239 was found in a room across from her room, sitting on the floor behind a couch. Continued review revealed at 6:30 AM the resident complained of pain to the right thigh. Medical record review of a statement dated 3/26/18 written by Licensed Practical Nurse #6 revealed "...(at) approximately 7AM patient was in dining room and complained of pain to right leg (upper) to the therapist when she tried to stand her up. Pain was reported to this writer by the therapist. Endorsed the c/o [complaint of] pain to right leg to incoming nursing supervisor to f/u [follow-up] [with] MD..." Medical record review of a statement dated 3/26/18 written by Physical Therapist #1 revealed "...Brought patient to P.T. [physical therapy] gym to stand in parallel bars. Patient unable to secondary to pain. Patient then told therapist she had fallen. Therapist took patient back to nurse and told nurse of patient's pain..." Review of a facility investigation dated 3/26/18 revealed Resident #239 had a fall resulting in fracture at 5:00 AM and the Medical Director/Attending Physician was notified at 7:30 AM and 8:30 AM with no response documented.	F 600	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** 04/17/18 staff began reassessing all residents at risk for pain. All those identified as" high-risk" for pain will be further evaluated utilizing the root cause analysis. Physician will be notified of pain analysis results. Plan of care will be updated based on the assessment findings. 4/17/18 an audit was conducted of the fall incidents utilizing "The Morse Code Fall Assessment" for the period of February, March and April 2018. Those identified as high-risk for falls will be further evaluated utilizing the" Root Cause analysis" to determine the individual intervention appropriate for each resident and will be documented on the Plan of Care.	

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F 600	Continued From page 9 Review of a Physician's Order dated 3/26/18 at 1449 (2:49PM) revealed a phone order received by the Attending Physician for, "x ray right femur, pelvis, pelvis [sic], and right hip r/t pain." Review of a Radiology Report dated 3/26/18 at 8:02 PM revealed, "...acute fracture involving the right subcapital hip... There is a right subcapital fracture with slight displacement..." Review of a Nurse's Note dated 3/26/18 at 2100 (9:00 PM) revealed, "...mobile xray resultes called to MD. Order obtained to send resident to [hospital named] ER for Eval. and Tx. as ordered. AMR ambulance service to transport..." Medical record review of the Medication Administration Report for March 2018 revealed an order dated 3/23/18 for pain to be assessed every shift. Continued review revealed a pain level of "...4. ." documented on the evening shift of 3/26/18. Continued review revealed no documentation of pain management interventions. Further review revealed Resident #239 was not provided with any pain interventions or medications from the first complaint of pain (6:30 AM) until arrival at hospital (2305 or 11:05 PM). Medical record review of a hospital Emergency Provider Report revealed, "Initial Greet Date/Time 3/26/18 2243 [10:43PM]." Medical record review of a hospital note dated 3/27/18 revealed Resident #239 was administered Morphine (opioid pain medication) 2 milligrams on 3/26/18 at 11:05 PM for pain. Further review revealed 16 hours had passed since Resident #239 received treatment or pain	F 600	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** A QAPI team consisting of three (3) nurses has been assigned to review all incident investigation reports to ensure accuracy and completion; including updating the care plan. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place** The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant	

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F 600	Continued From page 10 interventions for a fracture which occurred on 3/26/18 at 5:00 AM. Interview with the Director of Nursing (DON) on 4/18/18 at 8:30 AM in her office revealed she was made aware of Resident #239's fall on the morning it occurred. The DON said she was notified by the second shift nurse of the X-ray results. The DON confirmed the facility failed to implement measures to prevent an accident which resulted in a fracture for Resident #239 (HARM).	F 600	Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to accurately assess the use of insulin on the Minimum Data Set (MDS) for 1 of 42 sampled residents (Resident # 60) reviewed. Findings include: Medical record review revealed Resident #50 was admitted to the facility on 11/9/17 with diagnoses including Cellulitis, Hypertension, Osteomyelitis, Seizures and Type 2 Diabetes Mellitus. Medical record review of a Quarterly MDS dated 2/12/18 for Resident #50 revealed the resident did not receive any insulin during the 7 day review period. Interview with Resident #50 on 4/16/18 at 11:27	F 641	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The Physician order, the MAR and the diagnosis for resident #50 was reviewed to ensure insulin was given. Staff reviewed the MDS – Section N0350 for resident #50 on 2/12/18. The error was corrected on 4/18/18 by modifying the proper code to reflect insulin given times seven (7) days. (See ATTACHMENT "F")	

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F 600	Continued From page 10 interventions for a fracture which occurred on 3/26/18 at 5:00 AM. Interview with the Director of Nursing (DON) on 4/18/18 at 8:30 AM in her office revealed she was made aware of Resident #239's fall on the morning it occurred. The DON said she was notified by the second shift nurse of the X-ray results. The DON confirmed the facility failed to implement measures to prevent an accident which resulted in a fracture for Resident #239 (HARM).	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to accurately assess the use of insulin on the Minimum Data Set (MDS) for 1 of 42 sampled residents (Resident # 50) reviewed. Findings include: Medical record review revealed Resident #50 was admitted to the facility on 11/9/17 with diagnoses including Cellulitis, Hypertension, Osteomyelitis, Seizures and Type 2 Diabetes Mellitus. Medical record review of a Quarterly MDS dated 2/12/18 for Resident #50 revealed the resident did not receive any insulin during the 7 day review period. Interview with Resident #50 on 4/16/18 at 11:27	F 641	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** 4/18/18 all residents with insulin orders were identified utilizing the "Order Listing Report" from PCC. During the scheduled Care Plan Conference (Quarterly, Annual or Significant Change), MDS staff will again review all current medications to ensure they are appropriately coded in the MDS assessment.	

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F 600	Continued From page 10 Interventions for a fracture which occurred on 3/26/18 at 5:00 AM. Interview with the Director of Nursing (DON) on 4/18/18 at 8:30 AM in her office revealed she was made aware of Resident #239's fall on the morning it occurred. The DON said she was notified by the second shift nurse of the X-ray results. The DON confirmed the facility failed to implement measures to prevent an accident which resulted in a fracture for Resident #239 (HARM).	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to accurately assess the use of insulin on the Minimum Data Set (MDS) for 1 of 42 sampled residents (Resident # 50) reviewed. Findings include: Medical record review revealed Resident #50 was admitted to the facility on 11/9/17 with diagnoses including Cellulitis, Hypertension, Osteomyelitis, Seizures and Type 2 Diabetes Mellitus. Medical record review of a Quarterly MDS dated 2/12/18 for Resident #50 revealed the resident did not receive any insulin during the 7 day review period. Interview with Resident #50 on 4/16/18 at 11:27	F 641	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The DON and the newly formed QAPI team will review all MDS Assessments prior to transmission to ensure accuracy and completeness of MDS coding. In-service training was given to MDS staff regarding accuracy of coding physicians' orders.	

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F 641	Continued From page 11 AM in her room stated she received insulin injections daily. Medical record review of Physician's Orders dated 11/9/17 revealed an order for regular insulin 6 units subcutaneously 3 times a day for Type 2 Diabetes. Continued review revealed an order dated 11/9/17 for Lantus (long acting insulin) insulin 20 Units subcutaneously at bedtime related to Type 2 Diabetes. Medical record review of the "Blood Sugar Administration Record" for February 2018 revealed Resident #50 was administered regular and Lantus insulins as ordered from 2/1/18 - 2/28/18. Interview with Registered Nurse #2 (MDS Coordinator) on 4/18/18 at 9:40 AM in the conference room confirmed the facility failed to accurately assess Resident #50's use of insulin on the Quarterly MDS dated 2/12/18.	F 641	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director	
F 655 SS=G	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		

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F 655	Continued From page 12 Including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review and interview, the facility failed to identify interventions on a baseline Care Plan for 1 of 27 sampled residents (Resident #239) reviewed which resulted in a HARM (a situation in which the provider's noncompliance resulted in a negative outcome that had compromised the resident's ability to maintain and/or reach his/her	F 655	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** A reassessment of Resident #239 was conducted and interventions updated on the care plan 4/18/18 @6:20pm. Interventions included a "Sitter" in the room with resident #239 @7:01pm, 4/17/18. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The nurse will complete a Baseline Care Plan on the day of resident' admission. The care plan will include, but not be limited to the following: Initial goals based on admission Orders, Physician orders, Dietary Orders, Therapy services, Social Services, PASARR recommendation, If applicable, Risk, Benefits or Interventions related to plan of care.	

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F 655	Continued From page 13 highest practical physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services) for the facility's failure to provide fall interventions to keep the Resident safe after identification as 'high' falls risk. Findings include: Review of facility policy "Baseline Care Plans" dated 11/28/17 revealed "...To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission...The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan..." Medical record review revealed Resident #239 was admitted to the facility on 3/23/18 and readmitted on 4/2/18 with diagnoses including Fracture of Unspecified Part of Neck of Right Femur, Hallucinations, Other Reduced Mobility, Muscle Weakness, Other Abnormalities of Gait and Mobility, Heart Failure, Altered Mental Status, Diverticulosis of Small Intestine, Ischemic Cardiomyopathy, Chronic Obstructive Pulmonary Disease, Adult Failure to Thrive and Acute Angle-Closure Glaucoma. Medical record review of a Discharge Minimum Data Set dated 3/26/18 revealed Resident #239 had a Brief Interview for Mental Status score of 11, indicating mild cognitive impairment; required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene and required total dependence for bathing. Continued	F 655	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** A QAPI team consisting of three (3) nurses has been assigned to review all care plans within forty-eight (48) hours of admission to ensure accuracy and completions. (SEE ATTACHMENT "G")	

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F 655	Continued From page 14 review revealed the resident was not steady and only able to stabilize with staff assistance for moving from a seated to standing position. Further review revealed Resident #239 was at risk for falls and had a fall with major injury since admission. Medical record review of a "Morse Fall Scale" (an evidence based tool used to provide a quick and simple assessment of a patient's likelihood of falling) dated 3/23/18 at 2349 (11:49 PM) revealed Resident #239 had a score of 90 (Scoring: Low Risk 0-24, Moderate Risk 25-44, High Risk 45 or higher) indicating High Risk. Continued review revealed the following risk factors were documented: 1. Yes, the Resident has fallen before. (History) 2. Yes, the Resident has more than one diagnosis on the chart. (Secondary Diagnosis) 3. Yes, the Resident uses crutches, cane or walker. (Ambulatory Aid) 4. No, the Resident does not have an intravenous apparatus or heparin lock inserted. (IV or IV Access) 5. Resident is Impaired: 5a. difficulty rising from chair, uses chair arms to get up, bounces to rise. 5b. keeps head down when walking, watches the ground. 5c. grasps furniture, person or aid when ambulating. Cannot walk unassisted. 6. Yes, the Resident overestimates or forgets limits. RESULTS: High Risk for Falling SCORE: 90 Medical record review of Resident #239's Baseline Care Plan dated 3/23/18 revealed the	F 655	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director.	

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F 655	Continued From page 15 facility had identified falls as a safety concern. Further review revealed no identified interventions documented throughout Resident record regarding falls. Medical record review revealed Resident #239 had a fall on 3/26/18 which resulted in a femur fracture (HARM). Further review revealed the resident was admitted to the hospital on 3/26/18 and received surgery on 3/28/18 to repair the right hip fracture. Interview with the Director of Nursing (DON) on 4/18/18 at 8:30 AM in her office revealed Resident #239 had been identified as a high fall risk. The DON confirmed the facility failed to identify fall interventions on the Baseline Care Plan for Resident #239.	F 655		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, Physician's Orders, Radiology Report, Nurse's Notes, facility investigation and interview, the facility failed to prevent an accident which resulted in a fracture for 1 of 27 sampled residents (Resident #239) resulting in a HARM.	F 689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The facility assigned a "Sitter" to be in the room with resident #239 4/17/18 @ 7:01pm. and will continue to be in the room until resident is stable.	

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F 655	Continued From page 15 facility had identified falls as a safety concern. Further review revealed no identified interventions documented throughout Resident record regarding falls. Medical record review revealed Resident #239 had a fall on 3/26/18 which resulted in a femur fracture (HARM). Further review revealed the resident was admitted to the hospital on 3/26/18 and received surgery on 3/28/18 to repair the right hip fracture. Interview with the Director of Nursing (DON) on 4/18/18 at 8:30 AM in her office revealed Resident #239 had been identified as a high fall risk. The DON confirmed the facility failed to identify fall interventions on the Baseline Care Plan for Resident #239.	F 655		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, Physician's Orders, Radiology Report, Nurse's Notes, facility investigation and Interview, the facility failed to prevent an accident which resulted in a fracture for 1 of 27 sampled residents (Resident #239) resulting in a HARM.	F 689	The family was Informed 4/17/18 @ 7:01pm. Resident' care plan was updated accordingly 4/17/18. The Medical Director was Notified of the "Immediate Jeopardy" citation 4/17/18 @ 8:pm	

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F 689	Continued From page 16 Findings include: Review of facility policy "Fall Prevention and Investigation" dated 11/28/16 revealed "...Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls..." Medical record review revealed Resident #239 was admitted to the facility on 3/23/18 and readmitted on 4/2/18 with diagnoses including Fracture of Unspecified Part of Neck of Right Femur, Other Reduced Mobility, Muscle Weakness, Other Abnormalities of Gait and Mobility, Heart Failure, Altered Mental Status, Diverticulosis of Small Intestine, Ischemic Cardiomyopathy, Chronic Obstructive Pulmonary Disease, Adult Failure to Thrive and Acute Angle-Closure Glaucoma. Medical record review of a Discharge Minimum Data Set dated 3/26/18 revealed Resident #239 had a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment; required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene and required total dependence for bathing. Continued review revealed the resident was not steady and only able to stabilize with staff assistance. Further review revealed Resident #239 was at risk for falls and had a fall with major injury since admission. Medical record review of a facility investigation	F 689	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was conducted of the fall incidents for the period of February, March and April 2018. Twenty-six residents were identified as high-risk for falls. The Morse Code Fall Assessment was completed on all residents. In-service training was given to the nursing staff regarding "Safety Awareness", and "Fall Monitoring" beginning 4/17/18 and will be on going to ensure all staff that were not present at the first training session receive the training prior to beginning their shift. Staff will document the monitoring rounds on the "Monitoring Form/Sheet". (In-Services Training Sheets Attached)(SEE ATTACHMENT "H & I") Nurses and Supervisors will monitor for effectiveness and modify interventions when necessary	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445170	A. BUILDING _____ B. WING _____	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HEALTH AND REHAB CENTER	500 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16 Findings include: Review of facility policy "Fall Prevention and Investigation" dated 11/28/16 revealed "...Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls..." Medical record review revealed Resident #239 was admitted to the facility on 3/23/18 and readmitted on 4/2/18 with diagnoses including Fracture of Unspecified Part of Neck of Right Femur, Other Reduced Mobility, Muscle Weakness, Other Abnormalities of Gait and Mobility, Heart Failure, Altered Mental Status, Diverticulosis of Small Intestine, Ischemic Cardiomyopathy, Chronic Obstructive Pulmonary Disease, Adult Failure to Thrive and Acute Angle-Closure Glaucoma. Medical record review of a Discharge Minimum Data Set dated 3/26/18 revealed Resident #239 had a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment; required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene and required total dependence for bathing. Continued review revealed the resident was not steady and only able to stabilize with staff assistance. Further review revealed Resident #239 was at risk for falls and had a fall with major injury since admission. Medical record review of a facility investigation	F 689	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** In addition to Nurses and CNTs conducting daily routine monitoring on the residents identified as "high-risk" fall falls, supervisory monitoring will be made by Management Staff Q2hrs to ensure the Environment remains as free of accident hazards as is possible. Management staff monitoring assignments are as follows. Hallway – 100 – Medical Records Mgr. Hallway – 200- MDS Coordinator Hallway – 300- Dietary Mgr. Hallway - 400-Comm. Rel. Mgr. Hallway – 500- Rehab & Dietary Mgr. Hallway – 600- QA Coordinator	

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F 689	Continued From page 17 revealed on 3/26/18 at 5:00 AM Resident #239 was found in a room across from her room, sitting on the floor behind a couch. Continued review revealed at 6:30 AM the resident complained of pain to the right thigh. Review of a facility investigation dated 3/26/18 revealed Resident #239 had a fall resulting in fracture at 5:00 AM and the Medical Director/Attending Physician was notified at 7:30 AM and 8:30AM with no response documented. Review of a Physician's Order dated 3/26/18 at 1449 (2:49PM) revealed a phone order received by the Attending Physician for, "x ray right femur, pelvis, pelvis [sic], and right hip r/t pain." Review of a Radiology Report dated 3/26/18 at 8:02 PM revealed, "...acute fracture involving the right subcapital hip... There is a right subcapital fracture with slight displacement..." Review of a Nurse's Note dated 3/26/18 at 2100 (9:00 PM) revealed, "...mobile xray results called to MD. Order obtained to send resident to [hospital named] ER for Eval. and Tx. as ordered. AMR ambulance service to transport..." Interview with the Director of Nursing (DON) on 4/18/18 at 8:30 AM in her office revealed she was made aware of Resident #239's fall on the morning it occurred. The DON said she was notified by the second shift nurse of the X-ray results. The DON confirmed the facility failed to implement measures to prevent an accident which resulted in a fracture for Resident #239 (HARM).	F 689	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Plant & Maintenance Manager, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director.	
F 697	Pain Management	F 697		

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F 697 SS=G	Continued From page 18 CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to provide pain management post-fall with a fracture (HARM) after verbal complaints of pain for 1 of 27 sampled residents (Resident #239) reviewed. Findings include: Medical record review revealed Resident #239 was admitted to the facility on 3/23/18 and readmitted on 4/2/18 with diagnoses including Fracture of Unspecified Part of Neck of Right Femur, Other Reduced Mobility, Muscle Weakness, Other Abnormalities of Gait and Mobility, Heart Failure, Altered Mental Status, Diverticulosis of Small Intestine, Ischemic Cardiomyopathy, Chronic Obstructive Pulmonary Disease, Adult Failure to Thrive and Acute Angle-Closure Glaucoma. Medical record review of a Discharge Minimum Data Set dated 3/26/18 revealed Resident #239 had a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment. Continued review revealed the resident had vocal complaints of pain during the assessment review period. Further review revealed Resident #239 had a fall with major injury since admission.	F 697	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** The Care Plan for resident #239 has been reviewed and updated to evaluate and identify circumstances when pain can be anticipated. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** 04/17/18 staff began reassessing all residents at risk for pain. All those identified as" high-risk" for pain will be further evaluated utilizing the root cause analysis. Plan of care will be based on the assessment.	

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F 697	Continued From page 19 Medical record review of facility investigation dated 3/26/18 revealed at 5:00 AM Resident #239 was found sitting on the floor behind a couch in a room across the hall from her room. Continued review revealed at 6:30 AM the resident complained of pain to the right thigh to the Physical Therapist (PT). Medical record review of a statement dated 3/26/18 written by Physical Therapist #1 revealed "...Brought patient to P.T. [physical therapy] gym to stand in parallel bars. Patient unable to secondary to pain. Patient then told therapist she had fallen. Therapist took patient back to nurse and told nurse of patient's pain..." Medical record review of a statement dated 3/26/18 written by Licensed Practical Nurse #6 revealed "...[at] approximately 7AM patient was in dining room and complained of pain to right leg (upper) to the therapist when she tried to stand her up. Pain was reported to this writer by the therapist. Endorsed the c/o [complaint of] pain to right leg to incoming nursing supervisor to f/u [follow-up] [with] MD..." Review of a facility investigation dated 3/26/18 revealed Resident #239 had a fall resulting in fracture at 5:00 AM and the Medical Director/Attending Physician was notified at 7:30 AM and 8:30 AM with no response documented. Review of a Physician's Order dated 3/26/18 at 1449 (2:49PM) revealed a phone order received by the Attending Physician for, "x ray right femur, pelvis, pelvis [sic], and right hip r/t pain." Review of a Radiology Report dated 3/26/18 at 8:02 PM revealed, "...acute fracture involving the	F 697	In-service training was given to the nursing staff beginning 04/17/18 regarding "Pain Management"; Including recognizing when the resident is experiencing pain and identifying circumstances when pain can be anticipated. (In-service Training Sheets attached). - ATTACH. "C" In-services will be on going to ensure all staff that were not present at the first training session receive the training prior to beginning their shift. **What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The Management Staff conducting daily Supervisory monitoring will utilize the "IDT Daily Rounds Report Sheet" to document the findings. Questions #5 & #6 on the form relates to Pain. (See Attachment "B").	

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F 697	Continued From page 20 right subcapital hip... There is a right subcapital fracture with slight displacement..." Review of a Nurse's Note dated 3/26/18 at 2100 (9:00 PM) revealed, "...mobile xray resultes called to MD. Order obtained to send resident to [hospital named] ER for Eval. and Tx. as ordered. AMR ambulance service to transport..." Medical record review of the Medication Administration Report for March 2016 revealed an order dated 3/23/18 for pain to be assessed every shift. Continued review revealed a pain level of "...4..." documented on the evening shift of 3/26/18. Continued review revealed no documentation of pain management interventions. Further review revealed Resident #239 was not provided with any pain interventions or medications from the first complaint of pain (6:30 AM) until arrival at hospital (2305 or 11:05 PM). Medical record review of a hospital Emergency Provider Report revealed, "Initial Greet Date/Time 3/26/18 2243 [10:43PM]." Medical record review of a hospital note dated 3/27/18 revealed Resident #239 was administered Morphine (opioid pain medication) 2 milligrams on 3/26/18 at 11:05 PM for pain. Interview with the Director of Nursing (DON) on 4/18/18 at 8:30 AM in her office revealed she was made aware of Resident #239's fall on morning it occurred. The DON said she was also notified of the resident's complaint of pain. The DON confirmed the facility failed to provide pain management after verbal complaints of pain after a fall which resulted fracture for Resident #239.	F 697	Management staff monitoring assignments are as follows. Hallway-100- Medical Records Mgr. Hallway-200-MDS Coordinator Hallway-300-Dietary Mgr. Hallway-400-Comm. Relations Mgr. Hallway-500-Rehab & Dietary Mgr. Hallway-600-QA Coordinator **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The QAPI Committee will monitor the effectiveness of the interventions implemented and the include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Plant & Maintenance Manager, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director.	

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F 697	Continued From page 21 Refer to F-580, F-655, and F-689	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** 4/17/18 the Medical Director reviewed the medications of resident #239 and discontinued the psychotropic medication. 4/18/18 The Psyche NP evaluated and reviewed the medications of resident #239 and recommended not to resume PRN order. The record has been updated to meet the 14-day limitation rule. 4/18/18 The PRN psychotropic medication for resident #238 was reviewed by the PCP. A new order was received documenting the daily dose, frequency of administration and duration of use for the psychotropic medication.	

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F 758	Continued From page 22 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure as needed (PRN) psychotropic medications had a 14 day limitation or prescriber documentation with medical rationale for continuation for 2 of 7 sampled residents (Resident #238 and Resident #239) reviewed. Findings include: Medical record review revealed Resident #238 was admitted to the facility on 3/26/18 with diagnoses including Right Foot Pathological Fracture, Anxiety Disorder, Major Depressive Disorder, Dementia without Behavioral Disturbance, Chronic Obstructive Pulmonary Disease and Macular Degeneration. Medical record review of a Physician's Order dated 3/26/18 revealed Clonazepam (antianxiety) 1 mg (milligram) every 12 hours as needed for agitation. Continued review revealed no stop date.	F 758	**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Psyche NP re-evaluated all residents receiving PRN psychotropic medications to determine if the order should be extended beyond 14-days. Those identified as needing the PRN order extended beyond 14-days, the prescribing Practitioner documented the rationale. The resident's chart was updated to reflect same.	

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F 758	Continued From page 22 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure as needed (PRN) psychotropic medications had a 14 day limitation or prescriber documentation with medical rationale for continuation for 2 of 7 sampled residents (Resident #238 and Resident #239) reviewed. Findings include: Medical record review revealed Resident #238 was admitted to the facility on 3/26/18 with diagnoses including Right Foot Pathological Fracture, Anxiety Disorder, Major Depressive Disorder, Dementia without Behavioral Disturbance, Chronic Obstructive Pulmonary Disease and Macular Degeneration. Medical record review of a Physician's Order dated 3/26/18 revealed Clonazepam (antianxiety) 1 mg (milligram) every 12 hours as needed for agitation. Continued review revealed no stop date.	F 758	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** All newly admitted residents With psychotropic medications Will be assessed by the Community Relation Staff, Admitting Nurse and IDT members during the initial Care Plan Conference. Referrals will be made to the appropriate Practitioner, e.g. PCP, Psyche NP and/or Pharmacy Consultant to ensure The 14-ay evaluation is being enforced according to regulation. During the weekly Drug Regime Committee Meeting, 14-day rule for PRN medications will be discussed to ensure compliance. (SEE ATTACHMENT "J")	

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F 758	Continued From page 23 Medical record review of March 2018 - April 2018 Medication Administration Record (MAR) revealed the resident was administered the medication on the following dates: 3/27/18, 3/28/18, 3/30/18, 4/1/18, 4/2/18, 4/3/18 (twice), 4/4/18, 4/5/18 (twice), 4/6/18 through 4/9/18, 4/12/18 through 4/15/18 and 4/17/18. Medical record review revealed Resident #239 was admitted to the facility on 3/23/18 and readmitted on 4/2/18 with diagnoses including Fracture of Unspecified Part of Neck of Right Femur, Hallucinations and Altered Mental Status. Medical record review of a Physician's Order dated 4/2/18 revealed Zyprexa (antipsychotic) 2.5 mg every 24 hours as needed for agitation. Continued review revealed no stop date. Medical record review of the April 2018 MAR revealed the resident was administered the medication on the following dates: 4/3/18, 4/5/18, 4/7/18 through 4/9/18. Interview with the Director of Nursing on 4/18/18 at 6:10 PM in the conference room confirmed the facility failed to ensure PRN psychotropic medication had a 14 day limitation or documented rationale for continuation for Resident #238 and Resident #239.	F 758	**How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The QAPI Committee will monitor the effectiveness of the interventions implemented and the members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director.	
F 800 SS=F	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the	F 800		

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F 800	Continued From page 24 preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation and interview the facility failed to serve milk and protein shakes at the appropriate temperature for consumption for 87 residents. Findings include: Review of facility policy "Food Temperature and Preparation Service" revised 11/28/17 revealed "...The danger zone for food temperature is between 41 F [Fahrenheit] and 135 F [Fahrenheit]. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt, and cottage cheese..." Observation on 4/16/18 at 12:36 PM in the dietary department revealed milk and protein shakes (which contained milk products) were individually wrapped in plastic glasses placed on metal trays on racks during plating of the food. Continued observation revealed the milk temperature was 42 degrees Fahrenheit and the protein shakes were 44 degrees Fahrenheit. These temperatures were not within the safe range for consumption or distribution. Interview with the Food Service Supervisor on 4/16/18 at 12:40 PM in the dietary department confirmed that the milk and protein shake were not within the appropriate and safe range for consumption. Interview Food Service Supervisor on 4/18/18 at	F 800	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** All milk and shakes sitting at tray line was discarded and replaced with cold milk and shakes retrieved from the refrigerator at appropriate temperature. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Milk and Shakes will remain in the freezer until thirty (30) minutes prior to service. Milk and shakes will be placed on ice immediately after retrieval from freezer. Temperature will be checked before, during, and after tray line service. Temps will be maintained Below 40 degrees. (SEE ATTACHMENT "K")	

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F 800	Continued From page 24 preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation and interview the facility failed to serve milk and protein shakes at the appropriate temperature for consumption for 87 residents. Findings include: Review of facility policy "Food Temperature and Preparation Service" revised 11/28/17 revealed "...The danger zone for food temperature is between 41 F [Fahrenheit] and 135 F [Fahrenheit]. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt, and cottage cheese..." Observation on 4/16/18 at 12:36 PM in the dietary department revealed milk and protein shakes (which contained milk products) were individually wrapped in plastic glasses placed on metal trays on racks during plating of the food. Continued observation revealed the milk temperature was 42 degrees Fahrenheit and the protein shakes were 44 degrees Fahrenheit. These temperatures were not within the safe range for consumption or distribution. Interview with the Food Service Supervisor on 4/16/18 at 12:40 PM in the dietary department confirmed that the milk and protein shake were not within the appropriate and safe range for consumption. Interview Food Service Supervisor on 4/18/18 at	F 800	**What measure will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and** The Kitchen Supervisor and RD will monitor milk and shake temperatures for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.** The Kitchen Supervisor and RD will monitor the tray line for appropriate temperatures of all foods. All non-compliance concerns will be referred to the QAPI Committee for review of effectiveness of the interventions implemented.	

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445170	A. BUILDING _____ B. WING _____	04/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HEALTH AND REHAB CENTER	600 HICKORY HOLLOW TERRACE ANTIOCH, TN 37013

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F 800	Continued From page 25 8:47 AM in his office confirmed the facility failed to serve milk and protein shakes at the appropriate temperature for 87 residents.	F 800	The members include Administrator, Assistant Administrator, DON, DSD, QA Coordinator, MDS Coordinator, Activity Manager, Dietary Manager, Rehab Manager, Social Services Director, Medical Records Manager and RN/CNT. Monitoring will be conducted daily, weekly, monthly or as ordered by the Medial Director. Completion Date: May 4, 2018.	